| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185046 | A. BUILDING _____ B. WING _____ | 08/20/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER | 509 NORTH HAYDEN AVE. SALEM, KY 42078 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 281 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#1) in the selected sample of 15 and one resident (#16) not in the selected sampled. On 08/18/10 at 5:00 PM during a medication pass, Licensed Practical Nurse (LPN) #1 failed to administer in accordance with physician orders the residents' medications. Findings include:<br><br>1. Resident #1 was admitted to the facility with diagnoses to include Heart Failure, Depression, Anxiety, Peripheral Vascular Disease, and Diabetes.<br><br>A review of physician's orders, dated August 8, 2010, revealed an order for fasting blood sugar four times a day to include before meals and at bedtime. The times indicated were 6:00 AM, 11:00 AM, 4:00 PM and 8:00 PM with Regular Insulin one unit for every 10 above 200 and call the physician if reading greater than 400.<br><br>An observation during the medication pass, on 08/18/10 at 5:00 PM, revealed LPN #1 administered the resident's medication (Regular Insulin 6 units) at 5:15 PM to his/her abdomen.<br><br>2. Resident #16 was admitted to the facility with diagnoses to include Diabetic Foot Ulcers, Diabetes, and Severe Paranoid Schizophrenia.<br><br>A review of the physician's orders, dated 08/01/10 through 08/31/10, revealed an order for Novolin R | F 281 | 1. Residents # 1 and # 16 was not negatively affected by the deficient practice. LPN administering medication outside of time frame was counseled on 8/19/10 regarding medication administration guidelines.<br>2. Any resident that receives insulin have the potential to be affected.<br>3. The Licensed nurse was counseled on 8/19/10 on deficient practice and the remainder of the Licensed staff and medication aides were educated on 8/20/10 and 8/21/10.<br>4. Audits (Exhibit B) of the medication pass will be conducted weekly for 4 weeks, then monthly for 3 month, then quarterly by Nursing Director or designee to ensure compliance. All findings will be reported to the Director of Nursing Service. The Director of Nursing Service will report findings at the Quality Patient Care Committee meeting.<br><br>**Date corrective action completed for F 281.** | 9/03/10 |

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| F 281 | Continued From page 4<br>100 units/milliliter (ml), sliding scale as follows: four times daily at 6:00 AM, 11:00 AM, 4:00 PM and 9:00 PM, inject subcutaneous per sliding scale give one unit for every 10 greater than 200.<br><br>An observation during the medication pass, on 08/18/10 at 5:00 PM, revealed LPN #1 administered the resident's medication (Novolin R 8 units) at 5:20 PM to Resident #16's right arm.<br><br>An interview with LPN #1, on 08/19/10 at 4:40 PM, revealed she had an hour before or after to administer th medication. She reviewed Residents #1 and #16's orders and stated the Insulin was ordered at 4:00 PM. LPN #1 stated she did not administer the medication as ordered. "I gave the medication outside the time frame and that is my fault."<br><br>An interview with the Director of Nursing (DON), on 08/20/10 at 1:27 PM, revealed the staff have an hour before or after to administer the residents' medications. She stated there had been no reported problems of staff not being able to administer the medications within the time frame. The DON stated, "If the staff are running behind, then they should be asking for help." She reported LPN #1 informed her the medications were given outside the time frame and she expected the staff to administer the medication as ordered. | F 281 | | |